



The Indiana Family and Social Services Administration

Section 2703 Health Homes

July 13, 2012





Presentation Outline

- General Overview
 - Funding, Eligibility, Providers, Payment, Services
- Requirements
- Feedback from CMS
- Some Proposed Approaches
- Interactions
 - Waiver, managed care
- Next Steps





General Overview

- Affordable Care Act Section 2703; added Section 1945 to Social Security Act
- Effective 1/1/2011
- Goal is to expand on existing medical home models to build linkages to community and social supports and enhance the coordination of medical, behavioral health and long-term care services
- Can be implemented on a sub-state basis



Overview: Funding

- Health home services matched at 90% for 8 quarters from effective date of state plan amendment (SPA)
 - Rolling 8 quarters for geographic expansions or new populations



Overview: Eligibility

- Eligibility: Two or more chronic conditions, OR one condition with risk of another, OR serious and persistent mental illness
 - Statute lists mental health condition, substance abuse disorder, asthma, diabetes, heart disease, obesity
 - Other conditions can also be proposed
 - Services can be targeted (e.g, more severe conditions)
- Cannot exclude dual eligibles or HCBS waiver participants
- Can include medically needy, 1115 waiver



Overview: Providers

- Three types of providers:
 - Designated providers (e.g., physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency)
 - Team of health professionals which may include nurse care coordinator, nutritionist, social worker, etc.
 - “Health Team” as defined in Section 3502 of the ACA (Sec. 3502 provides a mechanism for the Secretary to provide funding for the establishment of interdisciplinary teams to provide Sec. 2703 services)



Overview: Payment

- Payment methodology is flexible
- Payment can be tiered to account for severity of conditions and “capabilities” of provider
- Payment methodology can be per member per month or an alternative structure



Overview: Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care from inpatient to other settings
- Individual and family support
- Referral to community and social support services
- Use of HIT as feasible and appropriate



Requirements

- As a new program, the health homes provision carries with it some monitoring and reporting requirements
 - Interim survey of States and independent evaluation will be followed by Reports to Congress
 - CMS recommends that States collect individual level data to compare the effect of the model across sub-groups
 - States will have to track avoidable hospital readmissions, calculate cost savings, and monitor the use of HIT
 - States also expected to track ED visits and NF admissions
 - CMS is defining quality measures



Some Approaches

Missouri

- CMHCs (SPMI, MH+, SUD+)
- Primary care practices (Asthma, CVD, Diabetes, DD, BMI > 25, other)

RI

- Community MH orgs
- SPMI

NC

- Patient-centered medical home (initial focus)
- Multiple conditions (e.g., CVD, asthma)

OH

- FQHC-based opiate treatment program
- SUD+



Interactions with Waiver

- The 2703 provision is well-suited to co-exist with a Section 1115 waiver
- DDRS is working on a program for their consumers
- Behavioral Health stakeholders have also been discussing options for the SMI population



Interactions with Managed Care

- CMS has stated that the health homes provision can be delivered through managed care contracts
 - Getting the enhanced match for MCO services will require making a strong case that the health home services are above and beyond the care management that an MCO would routinely provide